Indiana PERF
Public Employees' Retirement Fund

CLAIM FOR $12,000 LUMP SUM DEATH BENEFIT (FOR NON-SPOUSE)
1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND

State Form 53685 (8-08)
Approved by State Board of Accounts, 2008

1977 POLICE OFFICERS' & FIREFIGHTERS' PENSION & DISABILITY FUND
143 West Market Street
Indianapolis, Indiana 46204-2899
Toll Free: (888) 526-1687
TDD for hearing impaired: (317) 466-1000

* This agency is requesting disclosure of Social Security Numbers in accordance with IRS code; disclosure is mandatory and this form will not be processed without it.

INSTRUCTIONS:

1. *Please type or print.*
2. *This claim must be completed by the beneficiary, distributee, or duly appointed administrator of the deceased member's estate.*
   a. *If a claim is filed by an administrator, include both a copy of the court order establishing the appointment and a copy of the court document showing the tax identification number.*
3. *Please submit a copy of both the deceased member's and the applicant's birth certificate. Documents showing the date of birth may be a photocopy of a birth certificate, a baptismal or confirmation certificate, or a court decree. Attach an English translation to any foreign document.*
4. *Please submit a copy of the member's death certificate.*
5. *Please submit a copy of the applicant's Social Security card.*
6. *Please have this application notarized.*
7. *The child(ren) of the deceased member must complete page 3 of this form.*
8. *All of the above items must be provided; this application will not be processed without them.*
9. *If this form is not completed properly, it will be returned to you and the processing of your claim will be delayed.*

DECEASED MEMBER INFORMATION

Name of deceased member (*first, middle, maiden, last*) - *Please provide full name; do not use initials.*	Social Security Number *

Address at time of death (*number and street, city, state, and ZIP code*)

Date of birth (*month, day, year*)	Date of death (*month, day, year*)

APPLICANT INFORMATION

Full name (*first, middle, last*)	Social Security Number *	Telephone number ( )

Address (*number and street, city, state, and ZIP code*)

I hereby certify that, to the best of my knowledge, I am the *(check one)*: ☐ beneficiary ☐ distributee ☐ administrator of the deceased member's estate.

Signature of applicant	Date (*month, day, year*)

I, having been sworn, do on my oath depose and say that: I am the person who completed the foregoing claim form; I have carefully read the form and understand the same; all of the information I have provided and the questions I have answered are in full, complete and true, and no material facts have been concealed or omitted therefrom; and that said information and answers are for presentation to the board of trustees of the Public Employees' Retirement Fund of Indiana in making claim for a $12,000 death benefit that may be payable to me under IC 36-8-8-1 et seq.

Signature of applicant	Date (*month, day, year*)

CERTIFICATION OF NOTARY PUBLIC

STATE OF _____

COUNTY OF _____ SS:

The above information was subscribed and sworn to before me, a notary public, in and for the state and county above named, by the said applicant,

_____, on this _____ day of _____, 20_____.
Printed name of applicant

Signature of notary public	Printed name of notary public

County of residence	Date commission expires (*month, day, year*)

VOLUNTARY WITHHOLDING ELECTION

Distributions you receive from the plan [other than eligible rollover distributions, as defined in Internal Revenue Service Code Section 402(c)(4)] will be subject to Federal income tax withholding unless you elect not to have withholding apply. Withholding will apply only to the portion of your payment that is already included in your income subject to Federal income tax and will be like wage withholding.

Ten percent (10%) will be withheld from the taxable portion of your distribution for Federal income tax, unless you elect not to have the ten percent (10%) withheld.

If you do not want any Federal income tax withheld from your distribution, sign and date this election.

Even if you elect not to have Federal income tax withheld, you are liable for payment of federal income tax on the taxable portion of your distribution. You also may be subject to tax penalties under the estimated tax payment rules if your payments of estimated tax and withholding, if any, are not adequate.

☐ I do not want to have Federal income tax withheld from my distribution

Signature of applicant	Date (*month, day, year*)

STATE INCOME TAX

Do you want State income tax withheld from your lump sum death benefit? ☐ Yes ☐ No

If you checked "yes"or if neither box is checked, 3.4% of the taxable portion of your distribution will be withheld for State income tax purposes.

Signature of applicant	Date (*month, day, year*)

CERTIFICATION OF EMPLOYER

Name of employer	Account number of employer

Address of employer (*number and street, city, state, and ZIP code*)

Name of authorized agent	Telephone number ( )

I hereby certify that the last day in pay status for _____ (*Name of member*), _____ (*Social Security Number **),

was _____ (*Month, day, year*).

Signature of authorized agent	Date (*month, day, year*)

AFFIDAVIT FOR 1977 FUND $12,000 DEATH BENEFIT CLAIM
UNDER THE PROVISIONS OF IC 36-8-8-16

Part of State Form 53685 (8-08)

DECEASED MEMBER INFORMATION		
Name of deceased member (*first, middle, last*)	Social Security Number *	Date of death (*month, day, year*)
Address at time of death (*number and street, city, state, and ZIP code*)		

APPLICANT INFORMATION		
Name of applicant (*first, middle, last*)	Social Security Number *	Date of birth (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		

SWORN STATEMENT

Comes now, _____, the affiant herein, being duly sworn, says:
Name

The following person(s) is/are the only child(ren) of the above member *(list all children, including yourself)*:

Name	Address (*number and street, city, state, and ZIP code*)	Portion of account

I have notified each person identified in this affidavit of my intention to present this affidavit.

Signature of applicant	Printed name	Date (*month, day, year*)

I, having been sworn, do on my oath depose and say that: I am the person who completed the foregoing claim form; I have carefully read the form and understand the same; all of the information I have provided and the questions I have answered are in full, complete and true, and no material facts have been concealed or omitted therefrom; and that said information and answers are for presentation to the board of trustees of the Public Employees' Retirement Fund of Indiana in making claim for a $12,000 death benefit that may be payable to the listed heirs under IC 36-8-8-1 et seq.

Signature of applicant	Date (*month, day, year*)

CERTIFICATION OF NOTARY PUBLIC

STATE OF _____

COUNTY OF _____ SS:

Subscribed and sworn to before me, a notary public, in and for the state and county above named on this _____ day of _____, 20_____.

Signature of notary public	Printed name of notary public
County of residence	Date commission expires (*month, day, year*)